MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

37610

1. PLACE OF DEATH

County Johnson — Registration District No. 426 — File No.

Township Chilhowee — Primary Registration District No. 5591 — Registered No. 9.

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Robert Guy Trowbridge

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 18, 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	21

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) ----
(c) Name of employer ---

9. BIRTHPLACE (CITY OR TOWN) Near Magnolia, Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Guy Richard Trowbridge
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Woodward
(STATE OR COUNTRY) Okla.
12. MAIDEN NAME OF MOTHER Beulah Floy Barnhart
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Burborn
(STATE OR COUNTRY) Mo.

14. INFORMANT W. T. Windy
(Address) Chilhowee Mo

15. FILED 11/27, 1929 J. G. Beaty
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 21, 1929 19

17. I HEREBY CERTIFY, That I attended deceased from at time of death ....., 19....., to ....., 19..... that I last saw h..... alive on Nov. 21, 1929, 19....., and that death occurred, on the date stated above, at 10 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Strangulated Scrotal Hernia
about 2 hours (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) not determined
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF ---
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? palpation and characteric Symptoms
(Signed) R. L. Gill, M. D.
, 19 (Address) Magnolia, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Wall Cemetery	11-22 1929
20. UNDERTAKER	**ADDRESS**
Lunceny & Cook	Chilhowee Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.